STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013034	A. BUILDING: _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF COLLEGE PARK	8810 COLBY BLVD INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for an Initial State Licensure Survey. This visit included the investigation of Complaint IN00145149. Complaint IN00145149 - Substantiated - State deficiencies related to the allegations are cited at R0006, R0090, R0148, R0154, R0187, R273, R354. Survey Dates: February 27 & 28, 2014 and March 6, 2014 Facility number: 013034 Provider number: 013034 AIM number: NA Survey Team: Mary Jane G. Fischer RN Census bed type: Residential: 4 Total: 4 Census payor type: Other: 4 Total: 4 Sample: 5 These State findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed by Tammy Alley RN on March 12, 2014.	R 000		
R 006	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the	R 006		4/5/14

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R 006	Continued From page 1 resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to discharge a resident, in that when a resident displayed aggressive and threatening behaviors which endangered others, the facility did not provide a discharge for 1 of 5 sampled residents. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 02-27-14 at 10:15 a.m. Diagnoses included, but were not limited to, Lewy Body dementia and major depression. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 02-01-14 and resided at a secured dementia unit prior to the admission to the facility.	R 006		

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R 006	Continued From page 2 A review of the 24 hour Report book on 02-27-14 at 12:15 p.m., noted the following related to Resident "A." "02-11-14 3:00 to 11:00 p.m., - slightly agitated most of shift. 02-19-14 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14 7:00 a.m., to 3:00 p.m., had episode of aggression. 3:00 p.m., to 11:00 p.m., 30 minute checks - calm. 02-22-14 7:00 a.m., to 3:00 p.m., aggressive behavior during the day. 3:00 p.m., to 11:00 p.m., belt around neck." A review of the Nursing Progress Notes indicated the following: "02-02-14 at 8:30 p.m. - Resident refused all P.M. care. Would not allow nurse or CNA [certified nurses aide] to assist him in his p.j.'s [pajamas], to clean teeth or to take shoes off. Became agitated and stated numerous times 'I am sleeping in this and keeping my shoes on.' Attempts times 3." "02-15-14 at 1925 [7:25 p.m.] Clt. [client] talked with me about 'getting mad.' Hands started shaking more while he talked. [Resident name] 'afraid' of 'hurting with a bat' and stated he had, 3 times before in his life. Reassured clt. I respected his anger and I left room after stating to him 'the nurses and aides here would verbally remind him to walk towards his room if he appeared angry.'" "02-21-14 at 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and	R 006		

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R 006	Continued From page 3	R 006		

ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the DON. Writer and DON attempted to take res. into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych. [psychiatric] hospital for evaluation. POA [power of attorney] notified and refused to have the res. sent out anywhere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. apologized to writer and stated, 'I am sorry if I offended anyone.' MD notified. POA notified and stated that next time if this res. becomes agitated and attacks staff, to send res. to [name of hospital] Emergency."

"02-22-14 at 9:00 a.m. Resident agitated at breakfast. Attempted to hit CNA with rolling walker. Jabbed fork in the direction of nurse several times. Became calm after rest period. [Family member] made aware of behavior by DON."

"02-22-14 at 8:25 p.m. Resident up ambulating at 1400 [2:00 p.m.]. In DR [dining room] until 1440 [2:40 p.m.]. Stated 'it's terrible' when asked how his day going <sic>. 1500 [3:00 p.m.] in DR sitting holding phone, talking about [family member]. When I reminded res. [name of family member] coming tomorrow, res. replied, 'tomorrow, tomorrow,' Asked resident if he wanted to talk. Res. did state 'I'm, I'm not clear enough,' in regards to talking. 6:40 p.m. Checked on res. and saw his eyes open, and his

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R 006	Continued From page 4	R 006		

black belt around his neck medium tight. Began talking to res., paged DON from room, and attempted to remove belt. DON quickly [under one minute] she removed belt while restraining res. hands. DON to get Ativan [an anti-anxiety medication], page <sic> MD and request 9-1-1. Res. stating incomplete sentences talking about [name of family member], about res. older [sibling] being buried today states, 'there's no point.' Res. walking steady around room, grabbing TV cords, then shower hose, then TV box which he hit against his head. Verbally encouraging res. to sit down, let us help. DON administered Ativan .25 mg [milligrams] IM [intramuscularly] left deltoid while [resident's name] held by myself. Held [name of resident] hands [which had TV input cords around them loosely]. I led him to hallway to get away from mirror, cords, heavy objects in room. Ambulance crew present... transported to [name of hospital]."

"02-22-14 at 10:40 p.m., Res. neck faintly reddened at proximal tip [towards head] of belt location noted after belt removed."

"[Late entry] 02-23-14 at 6:25 p.m., - On 02-22-14 at 7:30 p.m., Call placed to [name of Administrator] to notify him [name of resident] had went out to ER [emergency room] and the events leading up to this transfer. Also the Executive Director was notified at this time as well voice mails were left with both parties."

"[Late entry] 02-23-14 at 6:28 p.m. - Return call from [name of administrator] he was informed of [name of resident] condition and transfer to ER."

During an interview on 02-27-14 at 11:00 a.m., the Director of Health Care indicated that on the day of the events on 02-21-14, the resident

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R 006	Continued From page 5	R 006		

rammed his walker into staff, including herself. The Director indicated she was recently recovering from knee surgery when the resident hit her with the walker. The Director further indicated the resident was picking up the walker and his foot trying to kick at staff and took the walker and "rammed it into the pillars" of the dementia unit. During an observation on 02-28-14 at 11:00 a.m., the "pillars" on the dementia unit were observed. Licensed Nurse #4 pointed out the areas where the resident "rammed" the walker. On one pillar was an area indented in approximately 1 inch by 2 inches and a metal corner protector was visible. The area lacked a painted surface. Adjacent to this pillar was another area, as identified by the nurse, where the resident rammed the walker. This area measured 1 inch by 1 inch. The Director further indicated she received a telephone call on a "Wednesday or Thursday" prior to the incident on 02-21-14 from the night shift nurse. "She told me she just wanted me to know that she recognized [name of Resident "A"] from his previous facility and that he had threatened the staff with a knife."

During an interview on 02-27-14 at 12:45 p.m., Licensed Nurse #6 indicated she had recognized the resident from the prior facility and was "concerned." "I told [name of the Director of Health Services]." The nurse went on to indicate that one day, at the previous facility, her aide went to check on [name of resident "A"] and he had a knife. The CNA tried to back away - and it looked like maybe an army knife. "We ran down the hall and he came out swinging with it - he was throwing things out of his room, heavy things that could hurt you. The police department had to be called."

During interview on 02-28-14 at 1:00 p.m., the

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R 006	Continued From page 6 Director of Health Services indicated on 02-21-14 the resident kept banging his walker into everything. "On the video you can actually see me holding onto the walker with one hand and I was talking to [name of physician] on the phone. The family wouldn't let us send him out to the hospital that the doctor wanted him to go to, that was on Friday - he tore up the entire dining room. I heard [name of Resident "D"] start to come out of her room and I told the CNA to get her back in there so she wouldn't get hurt. On Saturday was the incident with the belt. That night he was pulling at all kinds of cords, TV, just everything, he even tried to pull on the had held set in the shower. It wasn't until 911 got here that we could get the cords out of his hands and around his wrists." A review of the Facility "Transfer and Discharge" policy on 02-27-14 at 11:00 a.m., indicated the following: "It is Morningside of College Park's policy to notify in writing by certified mail, return receipt requested, in advance of any proposed transfer or discharge from the Facility. Reasons for discharge are the following: 3. The safety of individuals in the Facility is endangered; 4. The health of individuals in the Facility would otherwise be endangered." "The notice will be provided at least thirty (30) days in advance of the proposed transfer or discharge, unless any of the following applies:.. 3. An emergency arises in which the safety or health of individuals in the Facility would otherwise be endangered." During an interview on 02-28-14 at 11:00 a.m., the Director of Health Services indicated the	R 006		

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R 006	Continued From page 7 resident had not been given a discharge notice. This State finding relates to Complaint IN00145149.	R 006		
R 090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:	R 090		4/5/14

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R 090	Continued From page 8 (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request This RULE is not met as evidenced by: Based on record review and interview the facility failed to inform the Indiana State Department of Health of an unusual occurrence, in that when a resident displayed aggressive and threatening behaviors, and was found with a belt around his neck which resulted in a reddened area, the Administrator did not report the occurrence for 1 of 5 sampled residents who displayed aggressive and threatening behaviors to others and eventually himself. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 02-27-14 at 10:15 a.m. Diagnoses included, but were not limited to, Lewy Body dementia and major depression. These diagnoses remained current at the time of the record review.	R 090		

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R 090	Continued From page 9 The resident was admitted to the facility on 02-01-14 and resided at a secured dementia unit prior to the admission to the facility. A review of the 24 hour Report book noted the following related to Resident "A." "02-22-14 7:00 a.m., to 3:00 p.m., Aggressive behavior during the day. 3:00 p.m., to 11:00 p.m., belt around neck." A review of the Nursing Progress Notes indicated the following: "02-15-14 at 1925 [7:25 p.m.] Clt. [client] talked with me about 'getting mad.' Hands started shaking more while he talked. [Resident name] 'afraid' of 'hurting with a bat' and stated he had 3 times before in his life. Reassured clt. I respected his anger and I left room after stating to him 'the nurses and aides here would verbally remind him to walk towards his room if he appeared angry.'" "02-21-14 at 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the DON. Writer and DON attempted to take res. into his room. Res. came out still attacking the staff." "02-22-14 at 8:25 p.m. Resident up ambulating at 1400 [2:00 p.m.]. In DR [dining room] until 1440 [2:40 p.m.]. Stated 'it's terrible' when asked	R 090		

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R 090	Continued From page 10	R 090		

how his day going <sic>. 1500 [3:00 p.m.] in DR sitting holding phone, talking about [family member]. When I reminded res. [name of family member] coming tomorrow, res. replied, 'tomorrow, tomorrow,' Asked resident if he wanted to talk. Res. did state 'I'm, I'm not clear enough,' in regards to talking. 6:40 p.m. Checked on res. and saw his eyes open, and his black belt around his neck medium tight. Began talking to res., paged DON from room, and attempted to remove belt. DON quickly [under one minute] she removed belt while restraining res. hands. DON to get Ativan [an anti-anxiety medication], page <sic> MD and request 9-1-1. Res. stating incomplete sentences talking about [name of family member], about res. older [sibling] being buried today states, 'there's no point.' Res. walking steady around room, grabbing TV cords, then shower hose, then TV box which he hit against his head. Verbally encouraging res. to sit down, let us help. DON administered Ativan .25 mg [milligrams] IM [intramuscularly] left deltoid while [resident's name] held by myself. Held [name of resident] hands [which had TV input cords around them loosely]. I led him to hallway to get away from mirror, cords, heavy objects in room. Ambulance crew present... transported to [name of hospital]."

"02-22-14 at 10:40 p.m. Res. neck faintly reddened at proximal tip [towards head] of belt location noted after belt removed."

"[Late entry] 02-23-14 at 6:25 p.m. - On 02-22-14 at 7:30 p.m. Call placed to [name of Administrator] to notify him [name of resident] had went out to ER [emergency room] and the events leading up to this transfer. Also the Executive Director was notified at this time as well voice mails were left with both parties."

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R 090	Continued From page 11 "[Late entry] 02-23-14 at 6:28 p.m. - Return call from [name of administrator] he was informed of [name of resident] condition and transfer to ER." During an interview on 02-27-14 at 11:00 a.m., the Director of Health Care Services indicated she received a telephone call on a "Wednesday or Thursday" prior to the incident on 02-21-14 from the night shift nurse. "She told me she just wanted me to know that she recognized [name of Resident "A"] from his previous facility and that he had threatened the staff with a knife." During an interview on 02-27-14 at 12:45 p.m., Licensed Nurse #6 indicated she had recognized the resident from the prior facility and was "concerned." "I told [name of the Director of Health Services]." The nurse went on to indicate that one day, at the previous facility, her aide went to check on [name of resident "A"] and he had a knife. The CNA tried to back away - and it looked like maybe an army knife. "We ran down the hall and he came out swinging with it - he was throwing things out of his room, heavy things that could hurt you. The police department had to be called." During interview on 02-28-14 at 1:00 p.m., the Director of Health Services indicated on 02-21-14 the resident kept banging his walker into everything. On the video you can actually see me holding onto the walker with one hand and I was talking to [name of physician] on the phone. The family wouldn't let us send him out to the hospital that the doctor wanted him to go to, that was on Friday - he tore up the entire dining room. I heard [name of Resident "D"] start to come out of her room and I told the CNA to get her back in there so she wouldn't get hurt. On Saturday was the	R 090		

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R 090	Continued From page 12 incident with the belt. That night he was pulling at all kinds of cords, TV just everything, he even tried to pull on the had held set in the shower. It wasn't until 911 got here that we could get the cords out of his hands and around his wrists." A review of the Facility policy on 02-28-14 at 9:30 a.m., titled "State Reportable Unusual Occurrences," and dated as revised 02-2013, indicated the following: "Policy: The facility shall ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law. The administrator is responsible for immediately informing the Indiana State Department of Health, Division of Long Term Care by telephone, followed by written notice within twenty-four hours, of unusual occurrence that directly threaten the welfare, safety, or health of the resident or resident <sic>, including, but not limited to, any epidemic outbreaks, poisonings, fires, or major accidents." During an interview on 02-27-14 at 11:00 a.m., the Administrator indicated he made the decision not to report the incident to the Indiana State Department of Health. This State finding relates to Complaint IN00145149.	R 090		
R 148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds,	R 148		4/5/14

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	013034	A. BUILDING: _____ B. WING _____	C 03/06/2014

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R 148	Continued From page 13 and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. This RULE is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the security of residents, in that when residents had physician orders to reside in a secured unit, the facility failed to ensure the entrance door to the dementia unit remained secure and the nursing staff failed to answer the alert that the entrance door was unsecured for 1 of 1 dementia units observed. This deficient practice had the potential to affect 4 of 4 residents residing on the secured unit. (Resident B, C, D and E.) Findings include: During observation on 02-27-14 at 9:00 a.m., the Dietary Supervisor escorted this surveyor to the secured dementia unit. The Dietary Supervisor entered the code into the key pad to gain entrance to the unit. During this observation 4 resident's resided on	R 148		

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R 148	Continued From page 14 this unit - Resident's "B", "C", "D" and "E". Resident "B" was assessed on 12-17-13 and moved to the secured unit on 01-31-14. The resident's record indicated the resident had diagnoses which included, but were not limited to, dementia and debility. These diagnoses remained current at the time of the record review. At the time of admission the resident had physician orders which reflected "required placement of secured unit for safety." Resident "C" was assessed on 02-20-14 and moved to the unit on 02-22-14. The resident's record indicated the resident had diagnoses which included, but were not limited to, Alzheimer's dementia and falls with injury. These diagnoses remained current at the time of the record review. At the time of admission the resident had physician orders which reflected "required placement of secured unit for safety." Resident "D" was assessed on 01-27-14 and moved to the unit on 01-29-14. The resident's record indicated the resident had diagnoses which included, but were not limited to, dementia and depression. These diagnoses remained current at the time of the record review. At the time of admission the resident had physician orders which reflected "required placement of secured unit for safety." Resident "E" was assessed on 02-24-14 and moved to the unit on 02-26-14. The resident's record indicated the resident had diagnoses which included, but were not limited to, Alzheimer's dementia and hallucinations. These diagnoses remained current at the time of the record review. At the time of admission the resident had physician orders which reflected	R 148		

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R 148	Continued From page 15 "required placement of secured unit for safety." During an observation on 02-28-14 at 8:30 a.m., Resident "E" was observed pacing back and forth down the hallway, and going to the secured door. Additional observations on 02-28-14 at 9:00 a.m., and again at 12:30 p.m., the resident continued to pace around the unit. The resident stated he was waiting for his ride as he had been working all night. During interview on 02-28-14 at 9:00 a.m., licensed nurse #4 indicated the resident had been up all night, pacing back and forth. The nursing staff tried to engage the resident in various activities, however the resident would stand up from a seated position, and walk to the entrance door. During an observation on 02-28-14 at 12:35 p.m., the residents were ambulating to the dining room for the noon meal service. Observation on 02-28-14 at 12:50 p.m., the door to the secured unit was open and the entrance was unattended. During an observation on 02-28-14 at 12:52 p.m., the receptionist closed the door and indicated she was unsure of how long the door had been opened or who opened it. She further indicated "If you push the door back too hard it won't close." The Director of Health Services was notified of the lack of security to the secured dementia unit. During interview on 02-28-14 at 1:20 p.m., the Director of Health Services indicated she reviewed the video and the "Chef" pushed the door open at 12:43 p.m.	R 148		

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R 148	Continued From page 16 The door was left open and unattended for approximately 7 minutes. Further interview with the Director of Health Services indicated when the door is opened the nurses "pager" would alert them that the door was opened. Both the licensed nurse #4 and Certified Nurses Aide #5 were in the kitchen area of the dining room. The entrance door was not visible when the staff was in this area. During observation from 12:35 p.m., an audible alarm could be heard on the nurses pager system. The nursing staff remained in the dining area and did not check the security of the entrance door. During interview on 02-28-14 at 1:20 p.m., the Director of Health Services indicated she had problems with the nursing staff not answering the alert as prompted on the pager. "One day I stood in a resident room and pushed the call button just to check and see how long it would take for the nurses to answer the pager alarm. No one came so I confronted the nurses about no response to the alert. I'm not surprised about this situation." A review of the facility policy on 02-28-14 at 2:00 p.m., titled "Accident Prevention - Elopement Definition and Risk Assessment," The facility shall provide adequate supervision and assistive devices to prevent accidents related to elopement attempts. The facility is secured by key pad entrance and egress only. The resident's should be safe from elopement." A review of the facility "Mission Statement" for the "Morning side of College Park Reflections	R 148		

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R 148	Continued From page 17 Memory Support Care," on 02-28-14 at 9:30 a.m., indicated the following: "At Reflections our memory care community is dedicated to providing our residents who suffer from Alzheimer's or related dementia with the care and support they need to them as meaningful a left as possible. We do this by providing a safe environment.... " "Environmental Design - the physical environment of the Memory Support Care unit is designed to encourage and support independence while promoting safety. Our design features support the capabilities and well-being of persons with dementia as described below: Safety and Security Features: Electronically-controlled keypad locking mechanisms on exit doorways that lead to unsecured areas." This State finding relates to Complaint IN00145149.	R 148		
R 154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the kitchen was clean and maintained in good repair for 1 of 1 kitchens observed. Findings include:	R 154		4/5/14

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R 154	Continued From page 18 During observation on 02-27-14 at 1:15 p.m., with the Chef in attendance the following was observed: Upon entering the kitchen double doors a rack of what was identified as "clean dessert dishes" by the "Chef" was placed directly next to the garbage can. The Chef indicated the 'clean' dessert dishes should not be near the garbage. Adjacent to the janitor closet was a counter which had a red plastic bucket on the counter surface. The "Chef" indicated the bucket contained water with a "quat" (a sanitizing solution). When requested, the solution was tested for the appropriate amount of sanitizing solution. The "Chef" tested the solution, and indicated the testing strip indicated there was no sanitizing solution in the water. When questioned by the "Chef," the dietary aide indicated he "just made it." Throughout the kitchen an abundance of dried and fresh food debris was observed where the flooring and wall joined, and behind the food preparation areas, steam table, grill, stove, Vulcan oven and pastry preparation area. In addition many of the areas appeared to have a grease like appearance on the floor where the food debris was observed stuck to the grease surface. The dried/greasy areas spanned approximately 1 - 2 inches from the wall onto the floor surface. The tiled flooring throughout the kitchen had areas too numerous to count which were chipped, cracked or broken. During interview on 02-28-14 at 2:15 p.m., the Executive Director indicated the flooring was old and did not have a membrane	R 154		

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R 154	Continued From page 19 beneath the tiled surface, thus preventing the dietary staff from power washing the tiled floor. Observation of the "dessert refrigerator" dried food debris was observed along the side of the metal racks and the bottom surface of the refrigerator. The Chef indicated the dessert refrigerator "could use a good cleaning." A device identified by the "Chef" as a waffle iron, had an abundance of dried burnt on food beneath the metal surface on which the waffle iron had been placed. The Vulcan oven, which had an upper and lower unit had an abundance of burnt on brownish/black substance throughout. Located in the pastry preparation area were 6 large plastic bins/containers. The "Chef" indicated the contents in the bins/containers included bread crumbs, rice, corn meal, sugar, powdered sugar and flour. Within each container was a plastic scoop placed into each of the contents of the bin. During observation the ice machine also contained a scoop. The scoop was observed situated on top of the ice. 5 of 5 baking pans had a heavy build up of black burned on substance along and around all 4 edges of the pans. The air vent located in the wall above the "mechanical room" had a heavy build up of dark gray substance. The corner sections of the wall near the double doors of the kitchen lacked plaster and a metal strip was observed. The areas had sections of plaster missing.	R 154		

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R 154	Continued From page 20 During an additional observation on 02-28-14 at 12:00 p.m., the following was observed: The rack of dessert dishes was observed adjacent to the garbage can. The dietary staff was observed with gloves on both hands and removed a plastic container from the refrigerator. Within this container, the cook identified the contents as "tuna salad." During this observation the dietary staff member, removed the lid and picked up a scoop which had been placed into and on top of the prepared tuna salad. The scoop was wrapped in a clear plastic wrap. The staff member removed the plastic wrap and placed the wrap on to the counter surface. The staff member scooped out 1 scoop of tuna salad, placed the contents on to a plate and then re-wrapped the scoop in the same plastic wrap and placed the scoop back into the tuna salad mixture. The staff member placed the lid back on to the container and placed the container in the refrigerator. A review of the "Master Cleaning Checklist" on 02-28-14 at 9:00 a.m. indicated the "Convection Ovens - line and prep area - cleaned daily and the oven itself weekly," "Waffle Iron - lift up the waffle iron and wash counter underneath it.," Grill line after every shift," "Refrigeration Units - line and center area - daily." Review of the "Sanitation and Safety: Cleaning Standards for Food Contact and non-food contact surfaces," indicated the following: "POLICY: High standards of cleanliness and sanitation will be defined and maintained."	R 154		

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R 154	Continued From page 21 "PROCEDURE: For all Food Contact Surfaces: 1. Wash all surfaces that come into contact with food with manual dishwashing detergent and hot water. 2. Follow by wiping all surfaces with a Quaternary Sanitary Solution at the proper concentration recommended by the manufacturer." For Floors: 1. Sweep up all visible dirt and debris off of floors." This State finding relates to Complaint IN00145149.	R 154		
R 187	410 IAC 16.2-5-1.6(k) Physical Plant Standards - Deficiency (k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. This RULE is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper hot water temperatures for handwashing facility, in that the water temperature at the designated handwashing sink in the kitchen, the temperature registered greater than one hundred and twenty degrees Fahrenheit for 1 of 1 handwashing kitchen sink observed. Findings include: During a kitchen observation on 02-28-14 at 11:30 a.m., hands were washed upon entering the kitchen area. The water at the designated handwashing sink seemed hot, and steam came from the faucet as the water flowed from the faucet and into the sink. A request was made	R 187		4/5/14

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R 187	Continued From page 22 and Cook #9 took the temperature of the water with his dial thermometer. During this observation, the needle continued to move to the right, and when the needle passed 130 degrees, the cook moved the thermometer from the stream of water and placed the tip of the thermometer into the water which remained in the sink. A subsequent request was made for the Maintenance Supervisor to check for the hot water temperature at this handwashing sink. During interview on 02-28-14 at 12:30 p.m., the Maintenance Supervisor indicated the water temperature measured at 140 degrees (Fahrenheit) and he indicated he would "need to place an anti-scald device on it." This State finding relates to Complaint IN00145149.	R 187		
R 241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. This RULE is not met as evidenced by: Based on on observation, interview and record review the facility failed to ensure medications were given as prescribed for for 2 of 4 residents reviewed during medication pass, in a sample of 5. (Resident "E" and "C").	R 241		4/5/14

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R 241	Continued From page 23 Findings include: 1. The record for Resident "E" was reviewed on 02-27-14 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hallucinations, depression, hypertension, arthritis and edema to the right leg related to deep vein thrombosis. These diagnoses remained current at the time of the record review. A review of the admission physician orders dated 02-26-14 instructed the nurse to administer Miralax (a laxative) 17 grams every day. During the observation of medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medications for Resident "E." The Licensed Nurse then reached in to the bottom drawer of the Medication cart, and then placed a large bottle on the top surface. The medication was labeled "Miralax - 17 grams by mouth, place in 8 ounces of water." The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water and gave it to the resident. 2. The record for Resident "C" was reviewed on 02-27-14 at 12:00 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, falls with injury, fecal syncope, seizures and hypertension. These diagnoses remained current at the time of the record review. A review of the admission Physician orders, dated 02-22-14 instructed the nurse to administer Miralax (a laxative) 17 grams every day. Licensed Nurse #4 indicated the resident had	R 241		

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R 241	Continued From page 24	R 241		

physician orders for Miralax. The Licensed Nurse reached into the bottom drawer of the Medication cart, and then placed a large bottle on the top surface. The medication was labeled with the resident's name and physician. In addition the label indicated the medication was "Miralax" with directions to place "17 grams in 8 ounces of water." The Licensed Nurse measured the correct amount of the medication and placed the contents in 4 ounces of water and gave it to the resident.

3. A review of the facility policy on 02-28-14 at 9:00 a.m., titled "Medication Management Program," and dated 02/2013, indicated the following:

"POLICY: The administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call."

"PROCEDURE: The facility shall establish a medication management system that ensures the following: C. Medication are accurately administered in accordance with prescribed route, dosage and frequency by trained and authorized health services staff."

Review of a subsequent policy on 02-28-24 at 9:00 a.m., titled "Medication Management - Medication Administration," dated 02/2013, indicated the following:

"POLICY: The Administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises."

"PROCEDURE: 1. Medications ordered to be

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R 241	Continued From page 25 given by mouth, applied per nasal, eye, ear, rectal or vaginal routes, or per metered dose inhaler will be administered by licensed nurses or qualified medication aides in accordance with the physician's orders...."	R 241		
R 273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation and interview the dietary staff was observed with gloved hands, touching counter surfaces and food handling without performing handwashing during 1 of 1 lunch preparations. Findings include: During the meal service on 02-28-14 at 12:15 p.m., the dietary staff members at the steam table were observed. The dietary staff members had donned gloves and when a resident requested a certain food item, the dietary staff member would pick up the item with gloved hands. Multiple staff members were observed with gloves on, and when a resident requested a tuna croissant, the dietary staff member picked up a plate and then with gloved hands picked a lettuce, placed the lettuce on the plate and then placed a croissant onto the lettuce. The staff member then picked up the scoop and and placed amount of tuna onto the croissant. The staff member then took pieces of tomato slices and placed them around the	R 273		4/5/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 273	Continued From page 26 croissant. The staff member did not wash hands, change gloves or use tongs to place food items onto the resident's plate. This method of preparing was observed for 5 resident food preparations for the lunch meal. During interview on 02-28-14 at 1:35 p.m. the "Chef" indicated the dietary staff should be washing their hands in between changing gloves and shouldn't be touching other items with gloves on and then touching the resident's food. "It's like any other handwashing principle." This State finding relates to Complaint IN00145149.	R 273		
R 301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. This RULE is not met as evidenced by: Based on on observation, interview and record review the facility failed to ensure the appropriate	R 301		4/5/14

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	013034	A. BUILDING: _____ B. WING _____	C 03/06/2014

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R 301	Continued From page 27 labeling of prescription medications for 1 of 4 residents reviewed during medication pass, in a sample of 5. (Resident "E"). Findings include: 1. The record for Resident "E" was reviewed on 02-27-14 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, hallucinations, depression, hypertension, arthritis and edema to the right leg related to deep vein thrombosis. These diagnoses remained current at the time of the record review. During the observation of medication administration on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medications for Resident "E." The Licensed Nurse picked up a small bottle from the drawer of the medication cart and indicated the medication was scheduled to be given to the resident at 8:00 a.m.. The label on the bottle indicated the medication was Aspirin 81 mg. (milligrams). The bottle was not labeled with the the resident's full name, the physician's name, a prescription number, or directions for use. The Licensed nurse then picked up another small bottle and also indicated the medication was scheduled for 8:00 a.m., The label on the bottle indicated "Zantac [an anti-ulcer medication] 150 mg - one tablet every day." The medication label lacked a "route" for administration. The Licensed Nurse then reached in to the bottom drawer of the Medication cart, and then placed a large bottle on the top surface. The medication was labeled "Miralax [a laxative] - 17 grams by mouth, place in 8 ounces of water."	R 301		

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R 301	Continued From page 28 The Licensed Nurse measured the correct amount of Miralax and placed the contents in 4 ounces of water and gave it to the resident. During an interview on 02-28-14 at 2:00 p.m., the Director of Health Services indicated she instructed a nurse of the need to make sure the medications were labeled appropriately. "She didn't do it." 2. Review of the facility policy on 02-28-24 at 9:00 a.m., titled "Medication Management - Medication Administration," dated 02/2013, indicated the following: "POLICY: The Administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises." "PROCEDURE: 1. Medications ordered to be given by mouth, applied per nasal, eye, ear, rectal or vaginal routes, or per metered dose inhaler will be administered by licensed nurses or qualified medication aides in accordance with the physician's orders. 7. Medications ordered to be administered per staff or to be self-administered per the resident must be properly labeled to include the following: A. Resident's full name, B. Physician's name, C. Prescription number, D. Name of strength of the drug, E. Directions for use, F. Date of issue and expiration date [when applicable], G. Name and address of the pharmacy that filled the prescription."	R 301		
R 354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following:	R 354		4/5/14

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R 354	Continued From page 29 (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. This RULE is not met as evidenced by: Based on record review and interview the facility failed to ensure a complete transfer form, in that when a resident was sent to a local area hospital for behaviors, the transfer form lacked sufficient information related to the resident's condition/behaviors which prompted the transfer for 1 of 5 sampled residents. (Resident "A") Findings include: The record for Resident "A" was reviewed on 02-27-14 at 10:15 a.m. Diagnoses included, but were not limited to, Lewy Body dementia and major depression. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 02-01-14 and resided at a secured dementia unit prior to the admission to the facility. A review of the 24 hour Report book noted the following related to Resident "A."	R 354		

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R 354	Continued From page 30 "02-11-14 3:00 to 11:00 p.m., - slightly agitated most of shift. 02-19-14 3:00 to 11:00 p.m., nervous and scared. Thinks people are in his room. 02-21-14 7:00 a.m., to 3:00 p.m., had episode of aggression. 3:00 p.m., to 11:00 p.m., 30 minute checks - calm. 02-22-14 7:00 a.m., to 3:00 p.m., aggressive behavior during the day. 3:00 p.m., to 11:00 p.m., belt around neck." A review of the Nursing Progress Notes indicated the following: "02-21-14 at 10:10 a.m. "Res. [resident] sat in his walker in the dining room and had refused to get up from his walker. This writer and the CNA set next to the resident at the table to keep res. safe from falling from his walker. Res. stood up and ran his walker into the table. Res. ran his walker into everything on this unit. He was also running his walker into this writer and the CNA. The DON [Director of Nurses] was notified and had arrived to the unit. Res. was still extremely agitated and was also running his walker into the DON. Writer and DON attempted to take res. into his room. Res. came out still attacking the staff. MD [Medical Doctor] notified and ordered to send resident to psych hospital for evaluation. POA [power of attorney] notified and refused to have the res. [resident] sent out anywhere other than the [name of hospital], but does not want him sent out at this time. POA spoke to res. over the phone and was able to calm res. down. Res. sitting in TV room calm. No further agitation noted. Res. apologized to writer and stated, 'I am sorry if I offended anyone.' MD notified. POA notified and stated that next time if this res. becomes agitated and attacks staff, to send res. to [name of hospital] Emergency." "02-22-14 at 9:00 a.m. Resident agitated at breakfast. Attempted to hit CNA with rolling	R 354		

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R 354	Continued From page 31 walker. Jabbed fork in the direction of nurse several times. Became calm after rest period. [Family member] made aware of behavior by DON." "02-22-14 at 8:25 p.m. Resident up ambulating at 1400 [2:00 p.m.]. In DR [dining room] until 1440 [2:40 p.m.]. Stated 'it's terrible' when asked how his day going <sic>. 1500 [3:00 p.m.] in DR sitting holding phone, talking about [family member]. When I reminded res. [name of family member] coming tomorrow, res. replied, 'tomorrow, tomorrow,' Asked resident if he wanted to talk. Res. did state 'I'm, I'm not clear enough,' in regards to talking. 6:40 p.m. Checked on res. and saw his eyes open, and his black belt around his neck medium tight. Began talking to res., paged DON from room, and attempted to remove belt. DON quickly [under one minute] she removed belt while restraining res. hands. DON to get Ativan [an anti-anxiety medication], page <sic> MD and request 9-1-1. Res. stating incomplete sentences talking about [name of family member], about res. older [sibling] being buried today states, 'there's no point.' Res. walking steady around room, grabbing TV cords, then shower hose, then TV box which he hit against his head. Verbally encouraging res. to sit down, let us help. DON administered Ativan .25 mg [milligrams] IM [intramuscularly] left deltoid while [resident's name] held by myself. Held [name of resident] hands [which had TV input cords around them loosely]. I led him to hallway to get away from mirror, cords, heavy objects in room. Ambulance crew present... transported to [name of hospital]." "02-22-14 at 10:40 p.m. Res. neck faintly reddened at proximal tip [towards head] of belt location noted after belt removed."	R 354		

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R 354	Continued From page 32 "[Late entry] 02-23-14 at 6:25 p.m. - On 02-22-14 at 7:30 p.m. Call placed to [name of Administrator] to notify him [name of resident] had went out to ER [emergency room] and the events leading up to this transfer. Also the Executive Director was notified at this time as well voice mails were left with both parties." "[Late entry] 02-23-14 at 6:28 p.m. - Return call from [name of administrator] he was informed of [name of resident] condition and transfer to ER." During an interview on 02-27-14 at 11:00 a.m., the Director of Health Care indicated that on the day of the events on 02-21-14, the resident rammed his walker into staff, including herself. The Director indicated she was recently recovering from knee surgery when the resident hit her with the walker. The Director further indicated the resident was picking up the walker and his foot trying to kick at staff and took the walker and "rammed it into the pillars" of the dementia unit. During an observation on 02-28-14 at 11:00 a.m., the "pillars" on the dementia unit were observed. Licensed Nurse #4 pointed out the areas where the resident "rammed" the walker. On one pillar was an area indented in approximately 1 inch by 2 inches and a metal corner protector was visible. The area lacked a painted surface. Adjacent to this pillar was another area, as identified by the nurse, where the resident rammed the walker. This area measured 1 inch by 1 inch. The Director further indicated she received a telephone call on a "Wednesday or Thursday" prior to the incident on 02-21-14 from the night shift nurse. "She told me she just wanted me to know that she recognized [name of Resident "A"] from his previous facility and that he had threatened the staff with a knife."	R 354		

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R 354	Continued From page 33 During an interview on 02-27-14 at 12:45 p.m., Licensed Nurse #6 indicated she had recognized the resident from the prior facility and was "concerned." "I told [name of the Director of Health Services]." The nurse went on to indicate that one day, at the previous facility, her aide went to check on [name of resident "A"] and he had a knife. The CNA tried to back away - and it looked like maybe an army knife. "We ran down the hall and he came out swinging with it - he was throwing things out of his room, heavy things that could hurt you. The police department had to be called." During interview on 02-28-14 at 1:00 p.m., the Director of Health Services indicated on 02-21-14 the resident kept banging his walker into everything. On the video you can actually see me holding onto the walker with one hand and I was talking to [name of physician] on the phone. The family wouldn't let us send him out to the hospital that the doctor wanted him to go to, that was on Friday - he tore up the entire dining room. I heard [name of Resident "D"] start to come out of her room and I told the CNA to get her back in there so she wouldn't get hurt. On Saturday was the incident with the belt. That night he was pulling at all kinds of cords, TV, just everything, he even tried to pull on the had held set in the shower. It wasn't until 911 got here that we could get the cords out of his hands and around his wrists." A review of the "Resident Transfer Form," dated 02-22-14, identified the resident by name and the facility the resident was transferring to, but lacked information where the resident was transferred from, the names and addresses of all hospital and extended care facility from which Resident was discharged in past 60 days, the address of a	R 354		

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R 354	Continued From page 34 relative or guardian with telephone number and if the relative or guardian had been notified of the transfer, lack of routine and PRN (as needed) medications or the "pertinent information" related to the reason the resident needed to be transferred." This State finding relates to Complaint IN00145149.	R 354		
R 414	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. This RULE is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate handwashing, in that when a licensed nurse (#4) dispensed medications to the residents, the licensed nurse failed to perform handwashing after each direct resident contact for 4 of 4 resident observations. (Residents "C", "E", "B" and "D"). Findings include: 1. During an observation on 02-28-14 at 8:15 a.m., Licensed Nurse #4 prepared the medications for Resident "C". The licensed nurse had previously been in the common area of the TV lounge. The licensed nurse walked to the medication cart and prepared medications for the resident. Prior to preparing the medications the licensed nurse had not washed her hands. At 8:15 a.m. the licensed nurse administered the	R 414		4/5/14

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R 414	Continued From page 35	R 414		

medications to the resident. After completion of the resident taking the medications, the licensed nurse initialed the medication administration record that the medications were administered.

The licensed nurse then began preparation of medications for Resident "E." All mediations were prepared for the resident, and the medications were administered to the resident in the dining area. Upon completion of the resident taking the prescribed medications, the Licensed Nurse returned to the Medication Cart and initialed each medication as given to the resident.

The licensed nurse then prepared medications for Resident "B." The Licensed Nurse placed the medications into a plastic cup and proceed to the resident's room. The Licensed Nurse entered the resident's room, instructed the resident she had the morning medications prepared, and the resident then took the medications. The Licensed Nurse exited the resident room, returned to the medication cart, and initialed in the medication administration record the resident took the prescribed medications. The Licensed Nurse then picked up a bottle of hand sanitizer and rubbed the solution on her hands.

The Licensed Nurse then indicated she needed to prepare the medications for Resident "D." The medications were prepared, and the nurse walked to the resident's room. The resident was seated on a sofa and the nurse instructed the resident she had the morning medications. The resident took the prescribed medications. Upon completion, the licensed nurse exited the resident's room, ambulated to the medication cart and recorded/initialed in the medication administration record the resident took the prescribed medications.

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R 414	Continued From page 36 The nurse exited the medication preparation area and went to the TV lounge without washing her hands after resident contact. 2. Review of the facility policy on 02-28-24 at 9:00 a.m., titled "Medication Management - medication Administration," dated 02/2013, indicated the following: "POLICY: The Administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises." "PROCEDURE: 19. The licensed nurse and the qualified medication aide will administer medications by completing the following steps: A. Wash hands thoroughly according to facility policy." 3. Review of the facility policy on 02-28-14 at 9:00 a.m., titled, "Handwashing," and dated 02/2013, indicated the following: "POLICY: The facility shall required staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional standards. An Alcohol-based hand rub shall be available for had decontamination in certain clinical situations in accordance with CDC [Center for Disease Control] recommendations. 2. Frequency of handwashing: C. Before and after caring for each resident. G. After removing gloves."	R 414		